2009-2010 Regular Session
State Legislative End-of-Session Report

Priority Board Bills

AB 2 (De La Torre) Rescission of Health Insurance Coverage
This bill was vetoed by the Governor on 10/11/2009. This bill would have required DMHC and CDI to establish a rescission review process and imposed penalties on plans and insurers that prolong the review process or that fail to implement the review panel's decisions, and would have required that penalties be deposited into the Major Risk Medical Insurance Fund for purposes of MRMIP. For a summary of this bill see page 8 of this report.

AB 98 (De La Torre) Mandated Benefit: Maternity Coverage
This bill was vetoed by the Governor on 10/11/2009. This bill would have required individual or group health insurance policies that cover hospital, medical or surgical expenses to cover maternity services. For a summary of this bill see page 9 of this report.

AB 542 (Feuer) Hospital-Acquired Conditions
This is a 2-year bill. This bill would require MRMIB, in collaboration with DMHC and other departments, to adopt new regulations and implement non-payment policies regarding hospital-acquired conditions, which was a topic addressed by AB 2146 (Feuer, 2007). For a summary of this bill see page 15 of this report.

AB 718 (Emmerson) MRMIP Weighted Average Premium Calculation
This is a 2-year bill. This bill would redefine the "average premium" for guaranteed issue preferred provider arrangements offered to individuals pursuant to the federal Health Insurance Portability and Accessibility Act (HIPAA) and would require MRMIB to calculate these "average premiums" and provide them to the DMHC and CDI annually. For a summary of this bill see page 15 of this report.

AB 730 (De La Torre) Penalties for Unlawful Rescission of Health Insurance Policies
This bill was vetoed by the Governor on 10/11/2009. This bill would have allowed the State Insurance Commissioner to impose monetary penalties on health insurers who unlawfully rescind health insurance policies and would have required a portion of these penalties to be deposited into the Major Risk Medical Insurance Fund to be used for MRMIP. For a summary of this bill see page 12 of this report.

AB 786 (Jones) Individual Health Insurance Coverage Categories
This is a 2-year bill. This bill is similar to SB 1522 (Steinberg, 2007). It would require DMHC and CDI, by July 1, 2012, to develop a system to categorize all individual health care service plan contracts and health insurance policies into five coverage choice categories and would limit out-of-pocket costs for covered benefits. For a summary of this bill see page 16 of this report.

AB 1383 (Jones) Increase Payments to Medi-Cal Hospitals and Fund Children's Health
This bill was signed into law by the Governor on 10/11/2009. This statute requires DHCS to calculate and impose a provider fee on specified hospitals, contingent on federal CMS approval, to be used for making supplemental Medi-Cal hospital reimbursements, paying supplemental payments to managed care plans, and paying for health care coverage for children. For a summary of this bill see page 4 of this report.

AB 1422 (Bass) Medi-Cal Managed Care Plan Gross Premium Tax
This was signed into law by the Governor on 09/22/2009. It establishes a gross premium tax for Medi-Cal managed care plans and directs a portion of the revenues (an estimated $97 million in FY 9009-10) to MRMIB to fund the Healthy Families Program. For a summary of this bill see page 5 of this report.

AB 1568 (Salas) Children's Health and Human Services Special Fund for Revenues from AB 1422 (Bass)
This bill was signed into law by the Governor on 10/11/2009. This statute creates the Children's Health and Human Services Special Fund for the purpose of depositing and utilizing the revenues collected pursuant to AB 1422 (Bass). For a summary of this bill see page 6 of this report.

SB 227 (Alquist) MRMIP Expansion
This is a 2-year bill. This bill would, among other things, significantly alter the funding and benefit structure of MRMIP and would expand MRMIB's role in the coverage of high-risk individuals. For a summary of this bill see page 17 of this report.

SBX3 26 (Alquist) CHIPRA Implementation
This is a 2-year bill. This bill is identical to SB 311 (Alquist, 2009), which stated the intent of the Legislature to implement key elements of the federal Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). SB 311 died in the regular session. For a summary of this bill see page 1 of the special session report.

Assembly Bills Signed Into Law

AB 108 (Hayashi) Rescission of Individual Health Insurance Coverage
Version: Amended 07/23/2009
Sponsor: Author
Status: ***10/11/2009-SIGNED into law by the Governor as Chapter 406, Statutes of 2009***

This statute prohibits, after 24 months following issuance of an individual contract or policy, a health care plan or insurer from rescinding an individual contract or policy for any reason, or from canceling, limiting, or raising premiums on contracts or policies due to any omissions, misrepresentations, or inaccuracies in the application form, whether willful or not. The statute states it will not limit a plan or insurer's lawful options when a subscriber makes a willful misrepresentation.

Governor's Signing Message:

I am pleased to sign Assembly Bill 108.

This bill breaks new ground in the California health insurance market by prohibiting a health plan or insurer from rescinding, canceling, limiting the provisions or raising the premiums of an individual after 24 months. This bill will decrease the likelihood of inappropriate rescissions and more effectively enforce the existing limits on rescission. This bill also brings health insurance into line with other forms of insurance such as life and disability insurance. These providers are also legally prohibited from rescission of coverage after 24 months.

I am proud of the strong consumer protections the Department of Managed Health Care has successfully implemented over the past two years. The number of rescissions industry-wide has decreased significantly since 2005. Millions of dollars have been assessed against health plans; corrective action plans have been received and approved; revised consumer disclosures have been reviewed for literacy, consistency and compliance with the settlement agreements; and lastly, both the Department of Managed Health Care and the Department of Insurance are working together to ensure that all health plans meet the same standards of fairness and full disclosure. The market has changed – and it is because of my Administration's strong action in this area.

I appreciate the effort that went into this important measure and I believe it will bring consistency and security to the lives of many Californians.

AB 235 (Hayashi) Mandated Benefit: Emergency Psychiatric Services
Version: Amended 06/11/2009
Sponsor: California Hospital Association
Status: ***10/11/2009-SIGNED into law by the Governor as Chapter 423, Statutes of 2009***

This statute:

- Adds admission or transfer to a psychiatric unit within a general acute care hospital or to an acute psychiatric hospital to those emergency services that must be provided when necessary to relieve or eliminate a psychiatric emergency medical condition; and

---

Deleted bill content is ~~stricken~~, and new bill content or status is ***bold italic underlined***.

- Exempts Medi-Cal managed care plan contracts entered into with the State Department of Health Care Services (DHCS) from the statute's requirements to provide additional emergency services and care.

The Governor did not include a signing message for this bill.

AB 1383 (Jones) Increase Payments to Medi-Cal Hospitals and Fund Children's Health
Version: Amended 09/12/2009
Sponsor: Daughters of Charity Health System, California Hospital Association, California Children's Hospital Association
Status: ***10/11/2009-SIGNED into law by the Governor as Chapter 627, Statutes of 2009***

Effective January 1, 2010, this statute:

- Requires the Department of Health Care Services (DHCS) to calculate and impose a provider fee on hospitals until December 31, 2010, contingent on approval by the federal Centers for Medicare and Medicaid Services (CMS), and exempts specified public hospitals;
- Requires the fees to be placed into a fund to then be used to draw down federal funds;
- Requires DHCS to use the combined state and federal funds for supplemental reimbursements to hospitals and managed health care plans and to provide $80 million per quarter of the year for health care coverage for children;
- Specifies the method for calculating the fee and provides DHCS flexibility in adjusting the fee if needed;
- Requires DHCS to seek all federal approvals and waivers necessary to maximize federal financial participation and to implement the statute.

Governor's Signing Message:

I am signing Assembly Bill 1383.

While I was supportive of many types of provider fees in my 2007 health care reform proposal and even offered this very same solution several months ago to help address our budget shortfall, I would point out that this bill lacks key features that must be addressed in order for this bill's provisions to be implemented.

- This bill does not contain an urgency clause. Therefore, it will not go into effect until January 1, 2010. Any expectation that this bill can be implemented earlier is not feasible.
- There is no appropriation in this bill. Therefore, the significant departmental workload associated with implementing this bill has not been funded. No steps will be taken to implement this bill unless and until a subsequent appropriation is passed by the Legislature. The Department may, at its discretion, engage with the federal Centers for Medicare and Medicaid Services about the funding proposal as a means to seek preliminary feedback and ascertain whether further statutory changes are needed.

Deleted bill content is ~~stricken~~, and new bill content or status is ***bold italic underlined***.

- The bill contains no authority for the funds to be distributed to hospitals, or to provide funding for children's health coverage. There will be additional legislation needed for this authority as well.

The Department's ability to implement this bill will have to rely on actions that have yet to be taken up by the Legislature. I look forward to the expedient passage of subsequent legislation to address the appropriation and funding issues related with this bill.

AB 1422 (Bass) Medi-Cal Managed Care Plan Gross Premium Tax
Version: Signed 09/22/2009
Sponsor: Author
Status: ***09/22/2009-SIGNED into law by the Governor as Chapter 157, Statutes of 2009***

This bill:

- Creates an annual tax on Medi-Cal managed care health plans' total operating revenues, as defined;
- Directs 38.1 percent of the tax to the Department of Health Care Services (DHCS) for Medi-Cal and the remaining 61.59 percent (an estimated $97 million in FY 2009/10) to MRMIB for the Healthy Families Program (HFP) until January 1, 2011;
- Specifies the timing, frequency and method of reporting and paying these taxes and sets penalties for non-compliance;
- Allows DHCS to retroactively increase Medi-Cal rates and make payments to plans;
- Increases the HFP premiums for families with incomes between 150 and 250 percent of the federal poverty level (FPL). These premium increases are consistent with those approved by MRMIB at its August 27, 2009, Board meeting and would be effective November 1, 2009;
- Reaffirms the authority of MRMIB to adopt regulations to modify program requirements and operations on an emergency basis;
- Allows the transfer of state First Five Commission funds from other accounts to the Unallocated Account, under certain conditions.

This bill was an urgency measure and became effective immediately upon the Governor's signature.

Governor's Signing Message:

I am proud that the legislature, health plans and health care advocates were able to come together and agree on an innovative solution to protect the health care of California's most precious resource - our children. This bipartisan legislation means that hundreds of thousands of California children will continue to have access to health care coverage - without any new General Fund dollars. This shared solution is a great example of the type of options we should be considering in this economic time.

Deleted bill content is ~~stricken~~, and new bill content or status is ***bold italic underlined***.

AB 1541 (Assembly Health) Implementation of CHIPRA "Late Enrollee" Provision
Version: Amended 07/23/2009
Sponsor: Assembly Health Committee
Status: ***10/11/2009-SIGNED into law by the Governor as Chapter 542, Statutes of 2009***

This statute:

- Declares the intent of the Legislature to implement a specified provision of the federal Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 that extends the period of time during which an employee or dependent may enroll in group health care coverage after termination of his or her Medicaid or another state child health plan coverage;
- Raises the number of days from 30 to 60 that an enrolled eligible employee will have in which to request enrollment for a dependent after notifying the plan or insurer of the loss or pending loss of the dependent's coverage in HFP or AIM before the plan or insurer may consider the dependent a late enrollee. Prior law allowed plans and insurers to exclude late enrollees from coverage for 12 months following the late enrollee's application for coverage.

The Governor did not include a signing message for this bill.

AB 1568 (Salas) Children's Health and Human Services Special Fund for AB 1422 Revenues
Version: Amended 09/10/2009
Sponsor: Author
Status: ***10/11/2009-SIGNED into law by the Governor as Chapter 299, Statutes of 2009***

This statute, among other things, creates the Children's Health and Human Services Special Fund for the purpose of depositing and utilizing the revenues collected pursuant to AB 1422 (Bass).

The Governor did not include a signing message for this bill.

Senate Bills Signed Into Law

SB 630 (Steinberg) Mandated Benefit: Orthodontic Reconstructive Surgery for Cleft Palate
Version: Amended 09/04/2009
Sponsor: California Society of Plastic Surgeons
Status: ***10/11/2009-SIGNED into law by the Governor as Chapter 604, Statutes of 2009***

This statute is similar to SB 1634 (Steinberg, 2007), which was vetoed. This statute:

- Expands the current definition of reconstructive surgery, as of July 1, 2010, to include medically necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures, thereby requiring health plan contracts and insurance policies to cover these services;
- Excludes from this requirement Medi-Cal managed care plans that contract with the Department of Health Care Services that do not provide coverage for California Children's Services (CCS) or dental services.

The Governor did not include a signing message for this bill.

Deleted bill content is ~~stricken~~, and new bill content or status is ***bold italic underlined***.

Assembly Bills Vetoed

AB 2 (De La Torre) Rescission of Health Insurance Coverage
Version: Amended 08/17/2009
Sponsor: California Medical Association
Status: ***10/11/2009-VETOED***

This bill was substantively the same as AB 1945 (De La Torre, 2007). Among other things, the bill would have:

- Required health plans and insurers to obtain approval from the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI), respectively, before rescinding any health coverage;
- Required DMHC and CDI, beginning January 1, 2011, to jointly establish an independent review process for plans' and insurers' requests to rescind an enrollee's health coverage;
- Prohibited a plan or insurer from rescinding an individual health contract or policy unless the health plan or insurer demonstrated that there was cause, as specified;
- Required that the penalties collected from plans be deposited into the Managed Care Administrative Fines and Penalties Fund, and that the penalties collected from insurers be deposited into the Major Risk Medical Insurance Fund for purposes of the Major Risk Medical Insurance Plan (MRMIP), subject to appropriation by the Legislature;
- Exempted from the bill's provisions all health plan contracts with the Access for Infants and Mothers (AIM) program and the Healthy Families Program (HFP).

Governor's Veto Message:

I am returning Assembly Bill 2 without my signature.

I have repeatedly indicated I would support a bill that provides strong statutory protections for consumers against inappropriate rescissions by health plans. However, this bill continues to have a provision that benefits trial lawyers rather than consumers. I remain comfortable sending this bill back for a second time without my signature because of the strong consumer protections the Department of Managed Health Care and Department of Insurance have successfully implemented over the past two years. The number of rescissions industry-wide has decreased significantly since 2005. Millions of dollars have been assessed against health plans and insurers; corrective action plans have been received and approved; revised consumer disclosures have been reviewed for literacy, consistency and compliance with the settlement agreements; and lastly, the two departments are working together to ensure that all health plans meet the same standards of fairness and full disclosure.

The market has changed – and it is because of my Administration's strong action in this area.

The precedent-setting 4th District Court of Appeals decision in Hailey v. Blue Shield relied heavily on the Department of Managed Health Care's amicus brief. The court's reliance on this brief speaks to the strong work of the Department and the balance required when enacting consumer protections and ensuring access to the individual health plan market. I have no interest in overturning that appellate decision and the definitive interpretation of the post-claims underwriting statute.

Deleted bill content is ~~stricken~~, and new bill content or status is ***bold italic underlined***.

In addition, I have signed targeted measures that prohibit plans from financially incentivizing their employees to rescind or cancel policies; require plans to offer coverage to families when the individual on the contract has been rescinded or cancelled; and most recently, I have signed Assembly Bill 108 that will prohibit a health plan from rescinding or canceling a contract after 24 months.

I would request that the Legislature send me a bill that codifies the Hailey decision, as I have asked for since 2008. When that occurs, I will be happy to sign that bill.

AB 56 (Portantino) Mandated Benefit: Mammography Screening
Version: Amended 09/1/2009
Sponsor: American College of Obstetricians and Gynecologists
Status: ***10/11/2009-VETOED***

This bill would have:

- Required individual and group health care insurance policies to cover mammography screening and diagnosis beginning July 1, 2010. Current law already requires this of health care plans;
- Required health plans and disability insurers to provide enrollees with information regarding recommended timelines to undergo tests for the screening or diagnosis of breast cancer; and
- Added participating physician assistants to the list of providers who may refer enrollees for covered breast cancer diagnosis and screening.

Governor's Veto Message:

I am returning Assembly Bill 56 without my signature.

The addition of a new mandate, no matter how small, will only serve to increase the overall cost of health care. This, like other mandates, only increases cost in an environment in which health coverage is increasingly expensive.

California has over 40 mandates on its health care service plans and health insurance policies. While these mandates are well-intentioned, the costs associated with the cumulative effect of these mandates mean that these costs are passed through to the purchaser and consumer.

I continue to have serious concerns about the rising costs of healthcare and must weigh the potential benefits of a mandate with the comprehensive costs to the entire delivery system – and for that reason, I cannot support this bill.

AB 98 (De La Torre) Mandated Benefit: Insurer Maternity Coverage
Version: Amended 09/04/2009
Sponsor: California Commission on the Status of Women
Status: ***10/11/2009-VETOED***

This bill would have:

- Required all individual or group health insurance policies that cover hospital, medical or surgical expenses and are issued, amended, renewed, or delivered on or after January 1, 2010, to cover maternity services;

Deleted bill content is ~~stricken~~, and new bill content or status is ***bold italic underlined***.

- Required health insurers with pending or approved individual or group health insurance policy forms already on file with the California Department of Insurance (CDI) as of that date to submit, on or before March 1, 2010, a revised policy form that provides coverage for maternity services;
- Excluded specialized health insurance and other specified insurance coverage from the bill's requirements.

Governor's Veto Message:

I am returning Assembly Bill 98 without my signature.

I have vetoed similar bills twice before. The addition of this mandate must be considered in the larger context of how it will increase the overall cost of health care. This, like other mandates, only increases premiums in an environment in which health coverage is increasingly expensive.

Maternity coverage is offered and available in today's individual insurance market. Consumers can choose whether they want to purchase this type of coverage, and the pricing is reflective of that choice.

While the perfect world would allow for all health conditions to be covered, including maternity, I cannot allow the perfect to become the enemy of the good. There is a reason the individual insurance market regulated by the Department of Insurance is growing – consumers are choosing policies they can afford.

Essentially, I am faced with choosing between covering fewer people, but with better coverage – or allowing more people to buy a policy that offers reduced benefits at a lower cost. It is not an easy choice. However, because I continue to have serious concerns about the rising costs of healthcare and believe the potential benefits of a mandate of this magnitude will translate to fewer individuals being able to afford coverage, I cannot support this bill.

AB 244 (Beall) Mandated Benefit: Mental Health Services
Version: Amended 09/01/2009
Sponsor: Author
Status: ***10/11/2009-VETOED***

This bill would have:

- Required health care service plan contracts and health insurance policies issued, amended, or renewed on or after January 1, 2010, to include the diagnosis and treatment of a mental illness for a person of any age;
- Defined "mental illness" for this purpose as a mental disorder defined in the Diagnostic and Statistical Manual IV (DSM IV);
- Excluded accident-only, specified disease, hospital indemnity, Medicare supplement insurance, or specialized health insurance policies but would have included behavioral health-only policies; and
- Excluded CalPERS plans and insurers unless CalPERS purchases a plan, contract, or policy that provides mental health coverage.

Deleted bill content is ~~stricken~~, and new bill content or status is ***bold italic underlined***.

Governor's Veto Message:

I am returning Assembly Bill 244 without my signature.

I have vetoed similar measures twice before. The addition of a new mandate, especially one of this magnitude, will only serve to significantly increase the overall cost of health care. This, like other mandates, also increases cost in an environment in which health coverage is increasingly expensive.

California has over 40 mandates on its health care service plans and health insurance policies. While these mandates are well-intentioned, the costs associated with the cumulative effect of these mandates mean that these costs are passed through to the purchaser and consumer.

I continue to have serious concerns about the rising costs of healthcare and must weigh the potential benefits of a mandate with the comprehensive costs to the entire delivery system – and for that reason, I cannot support this bill.

AB 513 (De Leon) Mandated Benefit: Consultation and Equipment Related To Breast-Feeding
Version: Amended 09/01/2009
Sponsor: WIC Association
Status: ***10/11/2009-VETOED***

This bill would have required health care insurance contracts and policies that cover maternity care to also cover specified consultation and equipment or equipment rental related to breast-feeding.

Governor's Veto Message:

I am returning Assembly Bill 513 without my signature.

I share the author's interest in promoting safer, healthier outcomes for mothers and their children. My Administration has several programs dedicated to promoting and encouraging mothers to breastfeed their infants for the multitude of health benefits it provides.

However, the addition of a new mandate, no matter how small, will only serve to increase the overall cost of health care. This, like other mandates, only increases cost in an environment in which health coverage is increasingly expensive.

California has over 40 mandates on its health care service plans and health insurance policies. While these mandates are well-intentioned, the costs associated with the cumulative effect of these mandates mean that these costs are passed through to the purchaser and consumer.

I continue to have serious concerns about the rising costs of healthcare and must weigh the potential benefits of a mandate with the comprehensive costs to the entire delivery system – and for that reason, I cannot support this bill.

Deleted bill content is ~~stricken~~, and new bill content or status is ***bold italic underlined***.

AB 730 (De La Torre) Penalties for Unlawful Rescission of Health Insurance Policies
Version: Amended 08/18/2009
Sponsor: Insurance Commissioner
Status: ***10/11/2009-VETOED***

This bill would have:

- Allowed the State Insurance Commissioner to penalize health insurers who unlawfully rescind health insurance policies in an amount up to $5,000 for each unlawful rescission, and imposed a penalty of up to $5,000 for each act of post-claims underwriting;
- Authorized the Commissioner to increase the penalty up to $10,000 for each act or violation if the insurer knew or had reason to know that the act of post-claims underwriting was unlawful;
- Required the first $118 of each of these penalties to be deposited into the General Fund and the remainder of these penalties to be deposited in the Major Risk Medical Insurance Fund and to be used for the Major Risk Medical Insurance Program (MRMIP), upon appropriation by the Legislature;
- Imposed these penalties in lieu of the penalty imposed by current law that is capped at $118 per violation;
- Required that the civil penalties and disciplinary actions provided for in the bill be determined at a hearing in accordance with the Administrative Procedures Act.

Governor's Veto Message:

To the Members of the California State Assembly: I am returning Assembly Bill 730 without my signature.

This bill attempts to align enforcement provisions between the Department of Managed Health Care and the California Department of Insurance. However, it does not create this much-needed consistency, but instead continues to subject regulated entities to differing standards.

In addition, while I believe the Managed Risk Medical Insurance Program to be a possible and appropriate location for some of the penalties associated with these fines, I cannot support provisions that further limit revenue to the General Fund and decrease the state's ability to direct resources to its highest priorities.

For these reasons, I am unable to sign this bill.

Senate Bills Vetoed

SB 158 (Wiggins) Mandated Benefit: Human Papillomavirus Vaccination
Version: Amended 08/31/2009
Sponsor: American College of Obstetricians and Gynecologists
Status: ***10/11/2009-VETOED***

This bill is similar to bills AB 16 (Evans, 2007) and AB 1429 (Evans, 2007). It would have required that individual and group health care plan contracts and health care insurance policies that were amended or renewed on or after January 1, 2010, and that included coverage for treatment or surgery of cervical cancer, must also provide coverage for the human papillomavirus vaccination and would have added physician assistants to the list of those providers authorized to make referrals for such services.

Governor's Veto Message:

I am returning Senate Bill 158 without my signature.

I have vetoed similar bills twice before. The addition of a new mandate, no matter how small, will only serve to increase the overall cost of health care.

California has over 40 mandates on its health care service plans and health insurance policies. While these mandates are well-intentioned, the costs associated with the cumulative effect of these mandates mean that these costs are passed through to the purchaser and consumer.

I continue to have serious concerns about the rising costs of healthcare and must weigh the potential benefits of a mandate with the comprehensive costs to the entire delivery system – and for that reason, I cannot support this bill.

SB 161 (Wright) Mandated Benefit: Parity Coverage for Orally-Administered Cancer Medications
Version: Amended 08/17/2009, 08/31/2009 and 09/03/2009
Sponsor: Kerry's Touch African-America Breast Cancer Association
Status: ***10/11/2009-VETOED***

This bill would have:

- Required that health care service plan contracts and health insurance policies issued, amended, or renewed on or after January 1, 2010, and that cover cancer chemotherapy treatment, must also provide coverage for cancer medications administered orally;
- Specified that such coverage must be on an equal basis with coverage provided for cancer medications administered intravenously or injected;
- Required health plans and insurers to compare the percentage cost share for oral cancer medications and intravenous or injected cancer medications and apply the lower of the two as the cost-sharing provision for oral cancer medications;
- Prohibited health plans and insurers from increasing enrollee cost sharing for cancer medications at a greater rate than they increase cost sharing for other medications;
- Excluded CalPERS from these requirements.

Governor's Veto Message:

I am returning Senate Bill 161 without my signature.

While I have historically supported greater access to necessary pharmaceutical treatments and appreciate the author and sponsors' intent, I cannot support this particular measure. For those patients fortunate enough to have health coverage in today's economic environment, health plans already provide coverage for oral anticancer medications. This bill limits a plan's ability to control both the appropriateness of the care and the cost by requiring them to immediately cover every medication as soon as it receives federal approval regardless of the provisions of the health plan's formulary, placing them at a severe disadvantage when negotiating prices with drug manufacturers.

I do believe that oral anticancer medications can be more cost-effective and efficacious in some instances. If there is a way to provide greater access without increasing overall costs, I would be willing to reconsider such a measure next year. I would encourage a collaborative approach with my Administration, the health plans, and the pharmaceutical manufacturers next year on this topic.

2-Year Bills
MRMIB staff will resume reporting these bills beginning January 1, 2010

AB 542 (Feuer) Hospital-Acquired Conditions
Version: Amended 06/18/2009
Sponsor: Author
Status: 06/11/2009-Senate HEALTH (needs concurrence in Assembly). 2-YEAR BILL

This bill is similar to AB 2146 (Feuer, 2007). Among other things, the bill would:

- Require the Department of Managed Health Care (DMHC), in collaboration with the State Department of Public Health (DPH), the State Department of Health Care Services (DHCS), the Managed Risk Medical Insurance Board (MRMIB), the California Public Employees' Retirement System (CalPERS), and the Department of Insurance (CDI), to adopt and implement by regulation, by September 1, 2010, uniform policies and practices governing nonpayment by state public health programs to a health facility for hospital acquired conditions;
- Require DPH, DHCS, MRMIB, CalPERS and CDI to adopt regulations that are identical or substantially similar to these DMHC regulations;
- Prohibit health facilities from charging patients for care and services when payment is denied by MRMIB or by DHCS;
- Prohibit health facilities from charging for hospital acquired conditions and require the facilities to disclose the event to the applicable payer;
- Require implementation of its measures only to the extent that federal financial participation for state health programs is not jeopardized.

AB 718 (Emmerson) MRMIP Weighted Average Premium Calculation
Version: Amended 09/01/2009
Sponsor: Department of Managed Health Care
Status: 09/03/2009-Senate RULES (passed from Senate Appropriations). 2-YEAR BILL

This bill would:

- Redefine the maximum premiums for guaranteed issue preferred provider arrangements offered to individuals pursuant to the federal Health Insurance Portability and Accessibility Act (HIPAA) by health insurers regulated by the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI). These premiums are currently prohibited from exceeding the "average premium" paid by a subscriber in the Major Risk Medical Insurance Program (MRMIP) who is of the same age and resides in the same geographic region;
- Redefine "average premium" as the weighted average of the MRMIP average premium based on each health plan's aggregate enrollment in MRMIP in each geographic area; and
- Require MRMIB to calculate these "average premiums" and provide them to the DMHC and CDI annually.

AB 786 (Jones) Individual Health Insurance Coverage Categories
Version: Amended 09/04/2009
Sponsor: Health Access
Status: 09/08/2009-Senate INACTIVE FILE, (needs concurrence in Assembly). 2-YEAR BILL

This bill is similar to SB 1522 (Steinberg, 2007). Among other things, this bill would:

- Require the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI), by July 1, 2012, to jointly develop a system to categorize all individual health plan contracts and insurance policies into a total of no more than 10 coverage categories, two categories of which must be in common between the departments;
- Require the categories to be based on actuarial values or another reasonable alternative determined by CDI and DMHC and to be identified by benefit levels and out-of-pocket costs;
- Require all individual health care plan contracts or insurance policies issued, amended or renewed on or after January 1, 2011 to have a maximum limit of $5,000 per person per year on out-of-pocket costs for in-network providers and on covered emergency services and to index limit increases to the Consumer Price Index;
- Prohibit the family out-of-pocket limit from exceeding twice the limit for individuals, excluding premium payments or prepaid periodic charges;
- Allow these contracts or policies to include a separate limit on out-of-pocket costs for covered prescription drugs.

AB 1445 (Chesbro) Visits to Federally Qualified Health Centers and Rural Health Clinics
Version: Amended 06/01/2009
Sponsor: California Primary Care Association
Status: 07/09/2009-Senate Appropriations. 2-YEAR BILL

The bill would require federally qualified health centers (FQHCs) and rural health clinics (RHCs) to apply to the Department of Health Care Services for an adjustment to their per-visit rate when they count as a single visit the cost of multiple encounters with health professionals that occur on the same day at a single location. It would also require FQHCs and RHCs to bill a medical visit and another health visit that take place on the same day at a single location as separate visits.

AB 1503 (Lieu) Provider Reimbursement for Unpaid Emergency Health Care Services
Version: Introduced 02/27/2009
Sponsor: Health Access, Western Center on Law and Poverty
Status: 06/11/2009-Senate Health. 2-YEAR BILL

Among other things, this bill would:

- Adapt fair pricing provisions established for hospitals by AB 774 (Chan, 2005) to emergency physicians;
- Require providers to provide a fee discount for patients with high medical costs (as defined by the bill) and incomes at or below 350 percent of the federal poverty limit, This discount would limit payment to the provider to the greater of the rate paid by Medi-Cal, Healthy Families Program (HFP) or other state health program in which the provider participates;

- Require providers to notify patients who do not have third-party coverage that the patient may be eligible for Medicare, Healthy Families, Medi-Cal, California Children's Services Program or discounted payment care.

ACA 22 (Torlakson) New Cigarette Tax
Version: Introduced: 4/16/2009
Sponsor: Author
Status: 04/23/2009-Assembly Committees on Governmental Organization and Revenue and Taxation. 2-YEAR BILL

This bill, in addition to current taxes imposed by the Cigarette and Tobacco Products Tax Law, would:

- Tax cigarette distributors $0.074 for each cigarette distributed and for the wholesale cost of tobacco products;
- Tax dealers and wholesalers $0.074 for each cigarette or tobacco product they stock;
- Impose additional taxes on cigarette and tobacco product stamps.

ACA 27 Funding of State-Mandated Local Programs
Version: Introduced 09/11/09
Sponsor: TBD
Status: 09/11/2009-INTRODUCED. 2 YEAR BILL

This bill would:

- Amend the Constitution to prohibit the Legislature or any state agency from mandating on local governments by statute or regulation any new unfunded programs or higher levels of service;
- Make such statutes or regulations enacted or imposed on or after July 1, 2009 inoperative until the Legislature appropriates sufficient funds to implement them.

SB 227 (Alquist) MRMIP Expansion
Version: Amended 07/13/2009
Sponsor: Author
Status: 07/01/2009-Assembly APPROPRIATIONS (needs concurrence in Senate). 2-YEAR BILL

The Board originally took a position of "support if amended" on this bill. Because the author amended the bill to cap the maximum subscriber contribution at 125 percent of the standard premium for comparable coverage, the Board is now "in support" of the bill. SB 227 is similar to AB 2 (Dymally, 2007) and AB 1971 (Chan, 2005). The bill would ensure long-term stable funding for the Major Risk Medical Insurance Program (MRMIP), thereby expanding the program to cover more individuals.

To accomplish this, the bill would:

- Require health care plans and insurers to either provide guaranteed-issue coverage to individuals eligible for MRMIP or to pay a fee;
- Eliminate the annual $75,000 benefit limit;
- Require MRMIB to increase the lifetime limit to no less than $1,000,000;

- Require MRMIB, conditioned on the absence of a MRMIP waitlist, to establish a process for individuals in the Guaranteed Issue Pilot program to voluntarily re-enroll into MRMIP;
- Require MRMIB to establish premiums at no more than 125 percent of the standard average individual rate for comparable coverage, which is consistent with existing maximum subscriber contribution rates.
- Require MRMIB, in the absence of a MRMIP waiting list, to use federal funds to lower contributions for subscribers who are at or below 300 percent of the federal poverty level to no less than 6 percent of their income;
- Allow MRMIB, with any remaining federal funds, to lower contributions to no less than 6 percent of their income for subscribers with income over 300 percent but less than 400 percent of the federal poverty level.

Please see the letter of support in the July 22, 2009, Board materials for more information on this bill.

SB 543 (Leno) Minors: Consent for Mental Health Treatment
Version: Amended 09/03/2009
Sponsor: National Association of Social Workers, California Chapter; Mental Health America of Northern California; GSA Network; and Equality California
Status: 09/11/2009-Senate INACTIVE FILE, (needs concurrence in Senate). 2-YEAR BILL

This bill would:

- Allow a minor who is at least 12 years old to consent to outpatient mental health treatment or counseling services if the attending "professional person," as defined, determines the minor is mature enough to participate intelligently in the mental health treatment or counseling services;
- Require involvement of the minor's parents in the treatment or services unless the "professional person" determines, after consulting with the minor, that the parental involvement would be inappropriate;
- Expand the definition of a "professional person" to include a licensed clinical social worker, as specified, and a board-certified or board-eligible psychiatrist.